PRINTED: 09/28/2011

	ENTERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		00	ì í	PLETED	
		155003	A. BUILDING		08/25/	2011	
			B. WING	A DDDEGG CITY CTATE ZID CODE			
NAME OF	PROVIDER OR SUPPLIEI	R	1	ADDRESS, CITY, STATE, ZIP CODE			
MACON		NITED	l l	ROVIDENT DR			
MASON	HEALTH CARE CE	INTER	WARSA	AW, IN46580			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
F0000							
				_			
	This visit was for	or a Recertification and	F0000	September 13, 2011 Mrs. I			
	State Licensure	Survey.		Rhoades, DirectorLong Tel			
				Care DivisionIndiana State)		
	Survey Dates: A	August 22, 23, 24, 25,		Department of Health2 N. Meridian StreetIndianapolis			
	2011	14gust 22, 23, 21, 23,		Indiana 46204 Re: Mason			
	2011			Care Provider Number:	ricaiiii		
				155003Survey Dates: Aug	ust		
				22-25, 2011 Dear Mrs.			
	Facility number:	: 000003		Rhoades: Enclosed please find			
	Provider number	r :155003		our completed plan of corre	ection		
	AIM number: 10	00290600		responding to the recertific			
		3023000		survey conducted at our fa			
	Cumulari taana			ending 8/25/11 and the 250	67		
	Survey team:	DI TO		dated 8/25/11. All POC			
	Julie Wagoner, I			measures have been or wi			
	Tim Long, RN	(08/22, 08/23, 08/24,		fully implemented by Septe 24, 2011. Mason Health C			
	2011)			respectfully asks that our p			
	Christine Fodrea	a, RN		correction be considered to			
				as our allegation of complia			
	Census bed type	··		for the cited tags F225, F2			
	SNF:	04		F282, F315, F332, F441 a			
				F514, as of that date. I he	-		
	SNF/NF:	87		request a quick return of th			
	Total:	91		survey team to clear all cite			
				tags. As noted on the plan			
	Census payor ty	pe:		correction, the POC should construed as an admission			
	Medicare: 16	_		the validity of any of the cit			
	Medicaid: 56			Please be assured, howev			
	Other: 19			although the facility disagre			
				with the citations, we have			
	Total: 91			considered the survey con-			
				very seriously and have			
	Sample: 19			undertaken the necessary			
	1			measures to ensure finding	gs of		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

These deficiencies reflect state findings

cited in accordance with 410 IAC 16.2.

TITLE

compliance as of September 24.

in-services will be provided on a

2011. Quality monitoring and

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 4W4A11 000003 (X6) DATE

STATEMENT OF DEFICE AND PLAN OF CORRECT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE COI ILDING	NSTRUCTION 00	(X3) DATE COMPL	
		155003	B. WIN			08/25/2	011
NAME OF PROVIDER			•	900 PR	DDRESS, CITY, STATE, ZIP CODE OVIDENT DR W, IN46580		
PREFIX (EA)	CH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Quality	y review c	ompleted on September Faulkner, RN			continuing basis to assure a ongoing understanding and implementation of policies as procedures to ensure contin compliance. Please contact with any questions or conceryou may have. Thank you in advance for your cooperation assistance in this matter. Sincerely, Lillian J. Horton, HFA, MHAMason He CareAdministrator	nd ued me rns n	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155003	B. WING		08/25/2011
	PROVIDER OR SUPPLIER		900 PR	ADDRESS, CITY, STATE, ZIP CODE OVIDENT DR AW, IN46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must in have been found gor mistreating reside have had a finding nurse aide registry mistreatment of reof their property; a has of actions by a employee, which is service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including ir and misappropriate reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations and must prevent the investigation is the investigation is state survey and oworking days of the violation is verified action must be tak Based on interviolations.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged guistreatment all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated of to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective	F0225	1.) Facility Disclaimer	09/24/2011
	reported an allegation administrator imported an allegation and allegations.	ation of abuse to the mediately for 1 of 1 eged abuse. (Resident		2.) Credible Allegation of Substantial Compliance This Plan of Correction (POC	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155003	B. WIN			08/25/2	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2		1	OVIDENT DR		
MASON	HEALTH CARE CE	NTFR		1	AW, IN46580		
					,		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE
IAG		LSC IDENTIFTING INFORMATION)	+	IAU	prepared and executed beca		DATE
	#105)				it is required by the provision		
	Finding includes:				State and Federal Law, and		
					because Mason Health Care		
					agrees with the allegations		
	During the Resident/Surveyor group				contained there-in. Mason H	lealth	
	meeting, conducted on 08/23/11 at 10:00				Care maintains that each		
	A.M., Resident #105 indicated a third				deficiency does not jeopardiz		
	· ·	oken to her rudely			health and safety of the residence nor is it of such character as		
	_	ed for an incontinence			limit our capability to render	10	
	1				adequate care.		
	brief. She indicated she had reported the incident right away to the nurse.				Please let these POC respor	ises	
	incident right aw	ay to the nurse.			serve as the facilities Credibl		
					Allegation of Compliance 9/2	4/11.	
		or was queried, during the			- -		
	daily exit confer	ence on 08/23/11 at 3:30			F-225 Investigate/Report		
	P.M., regarding	the incident and the			Allegations/Individuals: This plan of correction is		
	investigation of	the incident was			prepared and executed beca	use	
		ever, the Administrator			the provisions of State and	400	
	1 -	d no knowledge of the			Federal law require it and no	t	
		f summation of the			because Mason Health Care		
		iven to the Administrator			agrees with the allegations m		
	during the daily				in the cited deficiencies. The		
	during the daily	exit conference.			facility maintains that the alle deficiencies do not individual		
	0.00/25/44	0.40.4.3.5.4			collectively jeopardize the he	-	
	On 08/25/11 at 1				and safety of the residents, r		
		dicated she had started			are they of such character so	as	
	the investigation	of the alleged verbal			to limit our capability to rende	er	
	abuse by an unid	lentified staff member to			adequate care.		
	Resident #105.	She indicated she had			It is facility practice to not employed		
	verified with RN	#16, a staff nurse, that a			individuals who have been foun guilty of abusing, neglecting, or		
		he Resident #105 had			mistreating residents by a court		
	1				law; or have had a finding enter		
	reported the incident and the nurse had failed to follow the facility's abuse protocol and notify the Administrator immediately of the allegation. The				into the State nurse aid registry		
					concerning abuse, neglect,		
					mistreatment of residents or		
	1	_			misappropriation of their proper	rty;	
	Administrator in	dicated she had					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	00	COMPLI	ETED
		155003	B. WIN			08/25/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	t .			OVIDENT DR		
MASON	HEALTH CARE CE	NTER			W, IN46580		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	-		DATE
	1 ^	16 because she had failed			and report any knowledge it has		
	to follow the fac	ility's abuse policy and			actions by a court of law agains employee, which would indicat		
	procedure. She indicated she had also				unfitness for service as a nurse		
	reported the incident to the Indiana State				or other facility staff to the State		
	Department of Health as required. She				nurse aide registry or licensing	Ĭ	
	indicated at the p			authorities.			
	1	perpetrator could not be identified due to			It is facility practice to ensure the	hat all	
					alleged violations involving		
	the resident's inability to remember the				mistreatment, neglect, or abuse,		
	aide's name or description.				including injuries of unknown s		
					and misappropriation of residen		
	A copy of a written statement by RN #16,				property are reported immediate	-	
	completed on 08	/25/11, indicated on			the administrator of the facility other officials in accordance wi		
	07/22/11 Residen	nt #105 had alleged that			State law through established	un	
	"someone told he	er that she was too big of			procedures including to the Stat	te	
	a girl to pee on h	-			survey and certification agency		
	a gar to per on a				It is facility practice to have evi		
	On 08/25/11 of A	:45 P.M., immediately			that all alleged violations are		
		•			thoroughly investigated; and to		
		al exit conference, the			prevent further potential abuse	while	
		dicated the facility had			the investigation is in progress.		
	1 *	cited for the same issue			It is facility practice to ensure the		
	and the allegatio	n had been made prior to			the results of all investigations		
	the facility's plar	of correction date for the			reported to the administrator or designated representative and to		
	tag. In addition,	the Administrator			other officials in accordance wi		
	indicated she had	d additional			State law (including to the State		
		f an interview, conducted			survey and certification agency		
		sident #105 in which she			within 5 working days of the	´	
		concerns regarding any			incident, and if the alleged viola	ation	
	1				is verified appropriate correctiv	e	
	allegation of verbal abuse or rudeness.				action is taken.		
	The administrator showed an interview				1. An intternal investtgatton w		
	document with "yes" marked next to the question regarding had any staff member verbally abused or been rude to them.				inittatted and ISDH nottffied offi a		
					allegatton offi abuse by residen#10		
					2. Sttaffi intterviewed tto ensu		
	The Administrate	or indicated the "yes" was			otther allegattons offi abuse has b	- 1	
	1	but she did not elaborate			verbalized by a residentt Iffi tthere	are	

000003

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	
		155003	B. WING			08/25/2	011
NAME OF P	ROVIDER OR SUPPLIER		Si	TREET AD	DDRESS, CITY, STATE, ZIP CODE		
					OVIDENT DR		
MASON I	HEALTH CARE CEN	NTER	I w	VARSAV	N, IN46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	on what incident	the resident was			any otther allegattons reportted ar		
	referring to and the	hen the Administrator			intternal investigation will be initta	atted	
	indicated she would not provide a copy of				and our abuse policy ffiollowed		
	the document bed	cause it was part of the			3. Sttaffi will be reinserviced or		
	facility's "QA" pr	ocess.			whatt is an allegatton when tto not the Administrattor and tthe abuse		
3.1-28(c)				policy.			
				4. Administtratto/idesignee will			
				monittor weekly by randomly			
				selecting three residents and			
				intterviewing tthem regarding tthe	ir		
				care and ttreattmentt while att Ma	son		
				Healtth Care This will conttnue x 4			
				wk tthen monittored tthru.Q.			
					montthly 2, tthen quartterly		
					tthereaffierThis will also be		
					discussed in Residentt Council		
					montthly witth any concerns		
					ffiorwarded tto tthe Administratto	r	
					immediattely 5. Septtember24, 2011.		
F0226	The facility must d			5. Septtember24, 2011.			
SS=D	written policies and procedures that prohibit						
	•	ect, and abuse of residents					
	and misappropriati	on of resident property.					
	Based on intervie	ew and record review, the	F0226	6	F-226 Develop/Implementt		09/24/2011
	facility failed to	ensure 1 staff followed			Abuse/Neglectt,ETC Policies:		
	the abuse policy	and procedure regarding			This plan of correction is		
	reporting abuse to	o the administrator			prepared and executed beca the provisions of State and	use	
		1 of 1 residents who			Federal law require it and not	t l	
	alleged abuse. (F				because Mason Health Care		
uneged abuse. (Resident #105)					agrees with the allegations m		
	Finding includes:				in the cited deficiencies. The		
	i manig merades.	•			facility maintains that the alle	-	
During the Resident/Surveyor group		ont/Summoron or			deficiencies do not individual collectively jeopardize the he		
	_				and safety of the residents, n		
	meeting, conducted on 08/23/11 at 10:00				are they of such character so		
	A.M., Resident #	105 indicated a third			to limit our capability to rende		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4W4A11 Facility ID:

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If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155003	B. WIN			08/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIER				OVIDENT DR		
	HEALTH CARE CE	NTER		WARSA	AW, IN46580		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	_	oken to her rudely			adequate care. Itt is ffiacilitty practtce tto develop	and	
	1 ~ ~	ed for an incontinence			implementt written policies and	allu	
	brief. She indicated she had reported the				procedures tthatt prohibitt		
	incident right aw	ay to the nurse.			misttreattmentheglectt, and abuse	e offi	
					residentts and misappropriatton of	offi	
	The Administrator was queried, during the				residentt propertty		
	daily exit conference on 08/23/11 at 3:30				1. An intternal investtgatton w	/as	
	P.M., regarding t	the incident and the			inittatted and ISDH nottffied offi a	-	
	investigation of t				allegatton offi abuse by residen#1		
	1	ever, the Administrator			2. Sttaffi intterviewed tto ensu		
	1 ^	l no knowledge of the			otther allegattons offi abuse has be verbalized by a residentt Iffi tthere		
		summation of the			any otther allegattons reportted a		
		ven to the Administrator			intternal investtgatton will be initt		
	during the daily				and our abuse policy ffiollowed		
	during the dairy	exit comercinee.			3. Sttaffi will be reinserviced o	n	
	On 08/25/11 at 1	0:10 A M tha			whatt is an allegatton when tto no	ttffiy	
		·			tthe Administtrattor and tthe abus	se	
		dicated she had started			policy.		
	1	of the alleged verbal			4. Administtratto/idesignee wil	l	
	1 *	entified staff member to			monittor weekly by randomly selecttng tthree residentts and		
		She indicated she had			intterviewing tthem regarding tthe	eir	
		#16, a staff nurse, that a			care and ttreattmentt while att M		
	1	ne Resident #105 had			Healtth Care This will conttnue x 4		
	reported the incid	dent and the nurse had			wk tthen monittored tthru. Q .		
		he facility's abuse			montthly №, tthen quartterly		
	protocol and not	ify the Administrator			tthereaffierThis will also be		
	immediately of the	he allegation. The			discussed in Residentt Council		
	Administrator in	dicated she had			montthly witth any concerns ffiorwarded tto tthe Administtratte	or	
	suspended RN #	16 because she had failed			immediattely	UI .	
	to follow the faci	ility's abuse policy and			5. Septtember24, 2011.		
		ndicated she had also					
	1 ^	dent to the Indiana State					
	Department of Health as required. She						
	indicated at the p	•					
		I not be identified due to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	li i	e survey Pleted /2011	
	PROVIDER OR SUPPLIER		STREET 900 PI	ADDRESS, CITY, STATE, ZIP ROVIDENT DR AW, IN46580	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
IAG		bility to remember the	IAU			DATE
	A copy of a writt completed on 08. 07/22/11 Resider "someone told he a girl to pee on he on 08/25/11 at 4 following the fin Administrator in previously been and the allegation the facility's plantag. In addition, indicated she had documentation or recently with Reshad denied any callegation of verl The administrator document with "question regarding verbally abused of The Administrator "not about that" I on what incident referring to and the indicated she wo	en statement by RN #16, /25/11, indicated on in #105 had alleged that er that she was too big of erself." :45 P.M., immediately all exit conference, the dicated the facility had exited for the same issue in had been made prior to a of correction date for the the Administrator I additional if an interview, conducted sident #105 in which she concerns regarding any ball abuse or rudeness. It is showed an interview eyes" marked next to the ing had any staff member for been rude to them. For indicated the "yes" was but she did not elaborate the resident was hen the Administrator uld not provide a copy of cause it was part of the				
	Review of the fa	cility's policy and				

PRINTED: 09/28/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
		155003	A. BUILDING B. WING		08/25/2011
	PROVIDER OR SUPPLIER HEALTH CARE CEI	NTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE OVIDENT DR AW, IN46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Misappropriation dated 08/2010, an included the followill ensure that a mistreatment, neglinjuries of unknown	glect or abuse, including wn source, are reported ne Administrator of the ner officials in state law through			
F0282 SS=D	facility must be pro- in accordance with plan of care. Based on observa- record review, th TED (antiemboli- ordered by the ph	,	F0282	F 282-Services by Qualiffied Persons/Per Care Plan: This plan of correction is prepared and executed becathe provisions of State and Federal law require it and no because Mason Health Care agrees with the allegations in the cited deficiencies. The facility maintains that the allegations of the cited deficiencies do not individual	t nade e eged

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155003	B. WIN			08/25/20	11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	OVIDENT DR		
MASON	HEALTH CARE CE	NTER		1	AW, IN46580		
			_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		ecord was reviewed			collectively jeopardize the he and safety of the residents, r		
	8/23/2011 at 4:00 P.M. Resident #76's				are they of such character so		
	diagnoses included but were not limited to				to limit our capability to rende		
	Alzheimer's dementia, high blood				adequate care.		
	pressure, and osteoporosis.				Itt is ffiacilitty practtce tto ensure t	thatt	
		•			services provided or arranged by t	the	
	A current physic	ian's order, dated			ffiacilitty are provided by qualiffied	d	
	5/25/2011, indicated knee high TED hose				persons in accordance witth each		
	· ·	ed in the morning and			residentt's written plan offi care		
		· ·			Correcttve actton cannott b	e	
	removed in the evening.				ttaken regarding tthe alleged		
					defficiency oftt tthe occurrence		
		12:25 P.M., Resident #76			happened in tthe pastt		
	was observed sit	ting up in her wheelchair			All residentts have tthe pott tto be affiectted by tthe alleged	enttai	
	in her room whil	e LPN #7 was			defficiency		
	administering no	oon medications.			3. Nursing sttaffi will be		
	I -	s not wearing TED hose.			reinserviced on ffiollowing each		
		<i>S</i>			residentt's plan offi car€.N.A.		
	On 8/23/2011 at	8:45 A.M., Resident #76			assignmentt sheetts will be review	red	
		ting up in her wheel chair			and updatted as needed		
					4. Residentts witth speciffic ne	eds	
		was not wearing TED			(i.e. tted hose) will be identtffied tt	hru	
	hose.				ttheir care plans DON/designee wi	II	
					conductt ffiacilitty roun ថន/ wk x 6v	/k	
	On 8/23/2011 at	10 A.M., Resident #76			tto ensure all intterventtons are		
	was observed in	her wheel chair in the			implementted This will tthen be		
	hall. She was no	t wearing TED hose.			monittored tthru Q . quartterly un	tti	
					100% compliance is achieved. 5. Septtember24, 2011.		
	On 8/23/2011 at	4:25 P.M. Resident #76			5. Septtember24, 2011.		
		her room in bed. She was					
	not wearing TED hose.						
	not wearing TEL	7 11050.					
	In an intermit	on 9/24/2011 of 10:05					
	In an interview on 8/24/2011 at 10:05						
		ndicated Resident #76					
	should have her	TED hose on.					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155003	A. BUILDING B. WING		08/25/2011
	PROVIDER OR SUPPLIER		900 PR	DDRESS, CITY, STATE, ZIP CODE OVIDENT DR W, IN46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 8/24/2011 at 10:10 A.M., RN #5 indicated if Resident #76 would have refused her TED hose, it would have been documented on the treatment record. A review of the treatment record, dated 8/2011, indicated on the dates of 8/22 and 8/23/ 2011, Resident #76 was wearing her TED hose. 3.1-35(g)(2)				
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infectinormal bladder fur Based on observatinterview, the fact decline in bladder identified and assessment was provided appropriate treatmurinary tract infectinormal bladder fur Based on observation in the fact decline in bladder identified and assessment was provided appropriate treatment.	ation, record review, and cility failed to ensure a	F0315	F-315: No CatthetterPreventt UTJ Resttore Bladder This plan of correction is prepared and executed becathe provisions of State and Federal law require it and no because Mason Health Care agrees with the allegations no in the cited deficiencies. The	ot e nade

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155003 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 PROVIDENT DR MASON HEALTH CARE CENTER WARSAW, IN46580 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE residents reviewed for incontinence in a facility maintains that the alleged deficiencies do not individually or sample of 19. (Resident #27) collectively jeopardize the health and safety of the residents, nor Finding includes: are they of such character so as to limit our capability to render adequate care. 1. During the initial tour of the facility, Itt is ffiacilitty practice tto ensure thatt conducted on 08/22/11 between 10:30 based on tthe residentt's A.M. - 11:30 A.M., the Unit Manager, comprehensive assessment; tthe LPN #9, indicated Resident #27 was ffiacilitty ensures tthatt a residentt who confused, required extensive staff entters tthe ffiacilitty witthoutt an indwelling catthetter is nott assistance for activities of daily living, catthetterized unless tthe residentt's had an intestinal infection, was clinical conditton demonstrattes tthatt incontinent of her bladder, and was on a cattherizatton was necessary and a specific toileting plan. residentt who is inconttnentt offi bladder received appropriatte Resident #27 was observed on 08/23/11 at ttreattmentt and services tto preventt urinary ttractt inffiecttons and tto 2:58 P.M., in a recliner in the lounge. The resttore as much normal bladder resident was heard asking to go to the ffiunctton as possible. bathroom. The resident was assisted to Residentt#27's Bowel and her wheelchair, taken to her room, and Bladder assessmentt and care plan toileted on a bedside commode. The will be updatted tto reffiectt tthe change resident did not void. in inconttnence. All residentts have tthe pottenttal tto be affiectted by tthe alleged The clinical record for Resident #27 was defficiency reviewed on 03/23/11 at 11:50 A.M. The A new nurse has been initial Minimum Data Set (MDS) designatted tto manage tthe Bowel assessment for Resident #27,. completed and Bladder program; she will on 05/27/11 indicated the resident was receive one on one inservicing on tthe ffiacilittes updatted policy occasionally (more than twice during the DON/Licensed designee will assessment period but not daily) monittor all residentts ffior a change in incontinent of her bladder. A toileting ttheir conttnence tthru tthe mostt plan was initiated on 05/14/11, prior to currentt MDS5x/wk x 6wk. the assessment. Monittoring will tthen occur montthly tthru Q.A.unttl 100% compliance is

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	li i	e survey pleted /2011	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE OVIDENT DR W, IN46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	The most recent assessment reviee 07/14/11 indicated declined and was incontinent of he incontinent but he times). A "quart completed on 07 was marked for 03 day void (patter Interview on 08/15 the MDS Coordit Corporate RN #1 employee had more review/update for voiding pattern ro 07/15/11, 07/16/16/15/11, 07/16/15/15/11, 07/16/15/15/15/15/15/15/15/15/15/15/15/15/15/	quarterly MDS w, completed on ed the resident had s now frequently er bladder (daily has some control at erly review/update", /14/11 indicated "NO" changes in assessment or ern). 25/11 at 4:00 P.M., with mator, RN #10 and 11, indicated a previous ismarked the Quarterly erm. They presented a ecord form, completed on 11, and 07/17/11. There essment completed cline in bladder esident #27. plan had been reviewed had been made; however, iew date was 07/15/11 ang patterning record The current care plan ident was "occasionally er bowels and bladder" eleted at 6:00 A.M., 9:00 ded.		IAG	achieved. 5. Septtember24, 2011.		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4W4A11

Facility ID:

000003

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/25/2011	
NAME OF F	PROVIDER OR SUPPLIER		l	T ADDRESS, CITY, STATE, ZIP CODE PROVIDENT DR	
MASON	HEALTH CARE CEI	NTER	l l	SAW, IN46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	procedure, titled, Bowel and Bladder Assessment, revised as of November 2008, and indicated by RN #11 as the current policy indicated the bladder assessment form was to be completed on all residents at the time of admission, if they developed incontinence, after removing or utilizing a urinary catheter, and for bladder retraining or incontinence management. RN #11 indicated it did not specifically instruct nursing staff to complete a new assessment if the resident's bladder incontinence worsened and she was unclear what was intended in the policy regarding bladder retraining or incontinence management. 3.1-41(a)(2)				
F0332 SS=D	medication error ragreater.	nsure that it is free of ates of five percent or			
	interview, the factor medication error of 12 residents of medications. Thrush medication were	ation, record review, and cility failed to ensure a rate of less than 5% for 2 bserved receiving ree (3) errors in observed during 40 error in medication	F0332	F-332 Free of Medication Er Rates of 5% or more: This p correction is prepared and executed because the provis of State and Federal law req and not because Mason Hea Care agrees with the allegat made in the cited deficiencie	lan of sions uire it alth ions

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4W4A11 Facility ID:

000003

If continuation sheet

Page 14 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155003 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 PROVIDENT DR MASON HEALTH CARE CENTER WARSAW, IN46580 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility maintains that the administration. This resulted in a alleged deficiencies do not medication error rate of 7.5 %. individually or collectively (Residents #72 and # 31) jeopardize the health and safety of the residents, nor are they of such character so as to limit our Findings include: capability to render adequate care. It is facility practice to 1. Resident # 72 was observed on 8/22/11 ensure that it is free of medication receiving his Humulin R-100, 3 units, error rates of five percent or administered by LPN #1 per physician's greater, 1. Corrective action cannot be taken for residents #31 order at 10:52 A.M. The resident was or #72 due to the alleged observed receiving his meal at 12:16 deficiency occurred in the past. P.M., in the assist dining room. This was 2. All insulin dependent residents 84 minutes after the resident received the have the potential to be affected by the alleged deficiency. 3. insulin. The resident was not Nurses will be inserviced on experiencing any obvious adverse effects correct policy and procedure from early administration of Humulin R. when administering insulin. 4. DON/Licensed designee will The scheduled time for the lunch meal in monitor residents receiving insulin the assist dining room was 12:15 P.M. to ensure administration occurs within 30 minutes before the Resident # 72 was observed on 8/24/11 resident's next meal. This will be receiving his Humulin R-100, 3 units, done 3x/wk x 6wk then be monitored thru Q.A. quarterly until administered by LPN #1, per physician's 100% compliance is achieved. 5. order at 11:10 A.M. The resident was September 24, 2011. observed receiving his meal at 12:13 P.M. Addendum:Licensed Unit in the assist dining room. This was 63 Managers, or licensed designee, will observe insulin administration minutes after the resident received the for those residents requiring insulin. The resident was not experiencing injection 5-10 minutes before a any obvious adverse effects from early meal 3x/wk x 6 wk then be administration of Humulin R. The monitored thru Q.A. quarterly until 100% compliance is achieved. scheduled time for the lunch meal in the assist dining room is 12:15 P.M. Review of Resident #72's most recent physician's orders from 8/1/11 indicated

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155003		(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED	
		155003	B. WIN			08/25/2	011
	PROVIDER OR SUPPLIER			900 PR	.DDRESS, CITY, STATE, ZIP CODE OVIDENT DR		
MASON	HEALTH CARE CEN	NTER		WARSA	W, IN46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION APPROPRIATE	
TAG	Humulin R was to subcutaneous per meals and at bedice the subcutaneous per mea	indicated Humulin R was ulin with a 30 - 60 function with a peak a 2 - 4 hours after given. histration is it indicated it was to be minutes prior to a meal. was observed on 8/24/11 malog, 7 units, LPN #1, per physician's M. The resident was higher meal at 12:18 P.M. ig room. This was 58 resident received her dent was not a obvious adverse effects histration of Humalog. The form the lunch meal in froom is 12:20 P.M. ent #31's most recent is from 8/1/11 indicated be administered is sliding scale before		TAG	DEFICIENCY)		DATE
		indicated Humalog was					

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		900 PR	ADDRESS, CITY, STATE, ZIP CO OVIDENT DR AW, IN46580	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	onset of function between 30 - 90 administered. U recommendation administered 5 - meal. An interview wit (DN) on 8/24/11 the facility policy ordered before a of the scheduled Review of the fa "Injections Subce 9/2005, indicated #15: "Insulin ne minutes before the scheduled with the scheduled in the scheduled in the scheduled with the scheduled in the scheduled in the scheduled in the scheduled in the scheduled with the scheduled in the schedu	th the Director of Nursing at 1:40 P.M., indicated y is to administer insulin meal within 30 minutes time for the meal. cility policy titled utaneous Insulin" revised				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	C	00	COMPLETED	
		155003	B. WING	u		08/25/2	011
				DEETAI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			OVIDENT DR		
MACONI	HEALTH CARE CE	NTED	I				
IVIASON	HEALTH CARE CE	NIER	l vv	ARSA	W, IN46580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0441	,	stablish and maintain an					
SS=D		Program designed to provide					
		nd comfortable environment					
		nt the development and					
	transmission of dis	sease and infection.					
	(a) Infection Contr	ol Program					
		establish an Infection Control					
	Program under wh						
	•	ontrols, and prevents					
	infections in the fa	•					
	(2) Decides what	procedures, such as					
	isolation, should b	e applied to an individual					
resident; and							
		cord of incidents and					
	corrective actions	related to infections.					
	(L) D (L) O						
	(b) Preventing Spi						
	· · ·	ction Control Program resident needs isolation to					
		d of infection, the facility					
	must isolate the re	-					
		st prohibit employees with a					
		ease or infected skin					
	lesions from direct	t contact with residents or					
	their food, if direct	contact will transmit the					
	disease.						
	, , ,	st require staff to wash their					
		direct resident contact for					
		ng is indicated by accepted					
	professional pract	ice.					
	(c) Linens						
	` '	andle, store, process and					
		as to prevent the spread of					
	infection.						
İ		ation, record review and	F0441		F-441 Infection Control, Prev	ent_	09/24/2011
		ility failed to ensure 2 of			Spread, Linens: This plan of		
				correction is prepared and			
		s (LPN #1, LPN #3),			executed because the provis		
		ng blood glucose levels,			of State and Federal law requ		
	followed instruct	tions for proper sanitation	1		and not because Mason Hea	lth	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION A DIFFERENCE 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155003	- 1	LDING		08/25/2	
		100000	B. WIN			00/23/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE OVIDENT DR		
MASON	HEALTH CARE CE	NTER		1	AW, IN46580		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ers. This practice had the			Care agrees with the allegati made in the cited deficiencie		
	l *	et 23 of 91 residents in the		The facility maintains that the			
	1 *	eived glucometer checks.			alleged deficiencies do not		
		facility failed to ensure 3			individually or collectively		
	of 4 staff member	ers (CNAs # 12, #13, #15			jeopardize the health and sa		
	and COTA #14)	followed isolation			of the residents, nor are they such character so as to limit		
	precautions for 2	2 of 2 residents in contact			capability to render adequate		
	isolation in a sar	nple of 19. (Residents			care. It is facility practice to		
	#27 and #63)				establish and maintain an		
					Infection Control Program		
Findings include:				designed to provide a safe, sanitary and comfortable			
				environment and to help prev	/ent		
	1. On 8/22/11 at 11:11 A.M., LPN #1 was				the development and		
		ng blood glucose levels			transmission of disease and		
		. LPN #1 wiped the			infection. It is facility practice		
		ucometer for 5 seconds			establish and Infection Contr Program under which it	ol	
		Cloth wipes and left the			investigates, controls, and		
	_	ne medication cart.			prevents infections in the fac	ility;	
	gracometer on the	ie medication cart.			decides what procedures, su		
	On 8/23/11 at 11	:28 A.M., LPN #3 was			as isolation, should be applied	ed to	
		ng blood glucose levels			an individual resident; and maintains a record of incider	ite	
		. LPN #3 wiped the			and corrective actions related		
		•			infections. It is facility practic		
	I -	ucometer with Super			that when the Infection Conti	rol	
	1	s for 10 seconds and left			Program determines that a		
	the glucometer of	on the medication cart.			resident needs isolation to prevent the spread of infection	n l	
	.	ul I DNI 1/2 0/22/11			the facility isolates the reside		
		th LPN #3 on 8/23/11 at			prohibits employees with a	·	
		cated for glucometer			communicable disease or	,	
	I -	edication cart has two			infected skin lesions from dir contact with residents or thei		
	1 -	the procedure is to wipe			food, if direct contact will trar		
	_	cometer and let air dry			the disease; and requires sta		
	for 5 minutes and	d alternate glucometers.			wash their hands after each		
				resident contact for which ha			
	On 8/24/11 at 11	:00 A.M., LPN #1 was			washing is indicated by acce	pted	

li ´		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155003	B. WIN	IG		08/25/2	011
NAME OF	PROVIDER OR SUPPLIEF	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	ROVIDER OR SULLEE			900 PR	OVIDENT DR		
	HEALTH CARE CE				AW, IN46580		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG		_:I:4. /	DATE
		ng blood glucose levels			professional practice. It is factorice that personnel must		
	for Resident #72. LPN #1 wiped the				handle, store, process and		
	outside of the gl	ucometer with Super			transport lines so as to preve	ent	
	Sani-Cloth wipe	s for 5 seconds and left			the spread of infection. 1.		
	the glucometer of	on the medication cart. On			Corrective action cannot be		
	8/24/11 at 11:15	A.M., LPN #1 checked			due to the alleged deficiency	,	
		e level for Resident #31			occurred in the past. 2. All	4a ba	
	_	lucometer as Resident			residents have the potential affected by the alleged defici		
		king Resident #31's blood			3. Staff will be reinserviced		
		•			isolation precautions. Nurses		
	glucose level, LPN #1 wiped the outside of the glucometer for 5 seconds with Super Sani-Cloth wipes.				be reinserviced on proper		
					procedure for proper sanitati	on of	
					the glucometers. 4.		
					DON/designee will observe s	staff	
	Review of the fa	cility policy "Glucometer			for proper procedures when		
	Cleaning/Disinfe	ecting Policy," revised			interacting with a resident on isolation precautions. Nurses		
	January 2010 inc				be observed cleaning their	> WIII	
	1	glucometer by wiping the			glucometers to ensure prope	er	
	outside of the gli				sanitation. This monitoring w		
	-	e. (See Manufacturer's			occur 3x/wk x 6wk then quar	•	
		c. (See Manufacturer s			thru Q.A. until 100% complia		
	Guidelines.)"				is achieved. 5. September 2		
					2011. Addendum:Resident # be educated regarding the	27 to	
		anufacturer's instructions			appropriate hand washing		
	1 ^	Cloth wipes indicated to			technique, if able, and the		
	disinfect and dec	odorize: "Use a wipe to			Licnesed Unit Manager, or		
	remove heavy so	oil. Unfold a clean wipe			licensed designee, to observ	e the	
	and thoroughly v	wet surface. Treated			resident technique 1x/wk. If		
	surface must ren	nain visibly wet for a full			able to teach the resident, th		
		Use additional wipe(s) if			CNA to ensure the resident is	S	
	` ′	continuous two (2)			capable of appropriate hand washing technique. If unable		
					then the CNA to wash the	,	
	inimute wet conta	act time. Let air dry."			resident's hands ensuring		
					appropriate technique is		
				accomplished after using the			
					toilet. Licensed Unit Manage		
					licensed designee, will obser	ve	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003			A. BUII	LDING	onstruction 00	(X3) DATE S COMPL 08/25/2	ETED
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	011
NAME OF P	PROVIDER OR SUPPLIEF	R		1	OVIDENT DR		
MASON	HEALTH CARE CE			1	AW, IN46580		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU	REGULATORT OR	LISC IDENTIFTING INFORMATION)		IAU	CNA for those residents not	ahle	DATE
					to perform the task 1x/wk.	2010	
	2. During the in	itial tour of the facility,					
	conducted on 08	/22/11 between 10:45					
	A.M 11:15 A.I	M., the Unit Manager,					
	LPN #9, indicate	ed Resident #27 was in					
	contact isolation	due to a bowel infection.					
	She indicated the	e resident was incontinent					
	of her bowels an	d bladder and was					
	toileted at specif	ic times.					
	On 08/23/11 at 2	2:56 P.M., Resident #27					
	was seated in a r	ecliner in the lounge on					
	the secured unit.	She verbalized the need					
	to go to the bath	room. At 3:00 P.M.,					
	Resident #27 wa	s transferred to her					
	wheelchair and t	aken to her room. CNA's					
	#12 and 13 donn	ed gloves and proceeded					
	to transfer the re	sident from her					
	wheelchair onto	a bedside commode.					
	CNA #12 remov	ed the resident's brief and					
	placed it in a tras	sh can. CNA #12 then					
	removed her glo	ves, held them in one					
	hand, exited the	room, and returned after					
	_	rash bag. She then					
	proceeded to lift	the lid of a red trash can					
	in the room, place	ee the gloves in the trash					
	can, and put a ne	ew pair of gloves on her					
	hands.						
	After the residen	t had attempted to void,					
	she was instructed	ed to wipe herself with					
		s and then to wipe her					
	hands with a diff	ferent disposable wipe.					

PRINTED: 09/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003		A. BUII	LDING	NSTRUCTION 00	(X3) DATE (COMPL 08/25/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	!			OVIDENT DR		
	HEALTH CARE CE			WARSA	AW, IN46580		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1710	†	,		1710	·		DATE
	Both CNA's removed their gloves and washed their hands, but the resident was						
		ash her hands prior to					
	exiting the room	_					
	exiting the room	•					
	The clinical reco	ord for Resident #27 was					
		23/11 at 11:15 A.M. The					
	resident had diag						
	_	cile (a bowel infection).					
	The resident was	,					
	medications Diff Stat and Flagyl to treat						
	the infection. The resident was diagnosed						
	with the infection	n on 08/15/11.					
	_	itial tour of the facility,					
		/22/11 between 10:30					
		M., LPN #9 indicated					
		s in contact isolation due					
		ion. She indicated the					
		fused, incontinent of his					
	bowels and was	assisted to toilet.					
	On 08/24/11 at 9	2:30 A.M., Resident #63					
		ing transferred by					
		Certified Occupational					
		nt (COTA), and CNA #15					
		to his wheelchair.					
	Neither employe	e washed their hands or					
		CNA #15 removed a gait					
		her waist and placed the					
		Resident #63. Both, she					
	~	transferred the resident to					
		CNA #15 then replaced					

000003

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155003	B. WIN			08/25/2011
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER				OVIDENT DR	
	HEALTH CARE CEI	NTER		WARSA	AW, IN46580	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCE)	DATE
		nd her waist and the				
	COTA pushed Resident #63 in his wheelchair out of the room to the therapy					
		mployee washed their				
		ed the resident to wash				
	his hands prior to	exiting the room.				
	The clinical record for Resident #63 was					
	reviewed on 08/2	24/11 at 9:15 A.M.				
	Resident #63 was admitted to the facility					
	from an acute care facility on 06/20/11.					
	The resident had diagnoses, including but					
		lostridium difficile (a				
		The resident was				
	· · · · · · · · · · · · · · · · · · ·	ibiotics, Vancomycin and				
	1	s bowel infection.				
	I lugyi to treat iii	5 00 Wel infection.				
	4. Review of the	e facility policy and				
	procedure, from	an APIC infection control				
	toolkit, dated 200	03, titled, "Policy for				
	Clostridium diffi	cile" indicated the				
	following: "It is	the policy of this facility				
	1	ct precautions for				
		ostridium difficile,				
	pseudomembran	,				
	1 *	ated colitis who are				
		ea stools due to the				
	1	following situations:				
		t is incontinent and				
		vironment with stool is				
		resident is noncompliant				
	with basic persor	_				
	_					
	· ·	nen contaminated stool				
	cannot be contain	ned, when the resident is				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155003	B. WIN			08/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	ę.		900 PR	OVIDENT DR		
	HEALTH CARE CE	NTER			AW, IN46580		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
	1	nnot comply with					
	appropriate hygiene measures"						
	Review of the most current APIC "Guide						
		on of Clostridium difficile					
	1	ttings" indicated the mendations: "gloves					
	1	•					
	1	before entering the room					
	1	healthcare providers					
		are and when in contact					
	with the patient's environmentWhen a						
	1 ^	(Clostridium difficile),					
	1	ation and movement					
		or cubicle should be					
	1	ally necessary purposes.					
	1	be taught to perform hand					
	1	movement from their					
	roomPersonne	l should be sure to clean					
	1	patient care equipment					
	that has been con	ntaminated. Reusable					
	equipment must	be cleaned and					
	disinfected betw	een patients. Whenever					
	possible, each pa	atient should be assigned					
	his or her own e	quipment to minimize					
	cross-contamina	tion"					
	Interview with the	ne Director of Nursing, on					
	08/25/11 at 11:0	0 A.M., indicated she had					
	the 2008 manual	for Clostridium difficile.					
	Interview with the	ne Regional Nurse					
		#15, on 08/25/11 at 3:00					
	1	she had more information					
	1	ncern with the facility's					
		however, on 08/26/11 a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/25/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		indicating the facility ormation regarding the					
F0514 SS=E	each resident in a professional stand complete; accurate accessible; and sy The clinical record information to identhe resident's asseand services provipreadmission screstate; and progress Based on interview the facility failed complete records reviewed for confacility failed to documentation for reviewed for TEI documentation (I facility failed to doc	ew and record review, I to maintain accurate and I for 4 of 19 residents I haplete records. The	F0514	F-514-Records-Complette/Accurate ccessible: This plan of correction is prepared and executed becathe provisions of State and Federal law require it and not because Mason Health Careagrees with the allegations rin the cited deficiencies. The facility maintains that the allegencies do not individual collectively jeopardize the heand safety of the residents, in	ause ot e nade e eged illy or ealth		

´		(X2) M				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155003	B. WIN			08/25/2	011	
NAME OF I	DDOVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF	PROVIDER OR SUPPLIEF	C		900 PR	OVIDENT DR			
	HEALTH CARE CE			WARSAW, IN46580				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG			DATE	
		ake and output records			are they of such character so to limit our capability to rende			
	(Resident #91 and Resident #58) and for 1				adequate care.	EI		
	of 19 residents re	eviewed for physician			It is facility practice to maintain	ı		
	notification docu	imentation (Resident			clinical records on each residen			
	#100).				accordance with accepted			
	ĺ				professional standards and prac	tices		
	Findings include	.•			that are complete; accurately			
	i manigs merade	·•			documented; readily accessible	; and		
	1 D 1 1/7/1				systematically organized.			
		s record was reviewed			It is facility practice to ensure the			
		0 P.M. Resident #76's			the clinical record contains suff			
	diagnoses included but were not limited to				information to identify the residence record of the resident's assessm	-		
	Alzheimer's dementia, high blood				the plan of care and services	ents,		
	pressure, and osteoporosis.				provided; the results of any			
					preadmission screening conduc	ted by		
	A current physic	ian's order, dated			the State; and progress notes.	,		
		ated knee high TED hose			 Correcttve actton cannott b 	e		
		ed in the morning and			ttaken ffior residen # ₹6, #58 and #	91		
	removed in the e	-			due tto tthe alleged defficiency			
	Tellioved in the e	vening.			occurred in tthe pasttResidentt#10			
	0 0/22/2011	10.05 D.M. D. '1. 4 1/7/			has discharged ffirom tthe ffiacilit			
		12:25 P.M., Resident #76			2. All residentts have tthe pott	enttal		
		ting up in her wheelchair			tto be affiectted by tthe alleged			
	in her room whil				defficiency			
	administering no	on medications.			Nursing sttaffi will be reinservised on ffiellowing resident	++/c		
	Resident #76 wa	s not wearing TED hose.			reinserviced on ffiollowing resider plan offi careC.N.A. assignmentt	III S		
					sheetts will be reviewed and upda	tted		
	On 8/23/2011 at	8:45 A.M., Resident #76			as needed. The electtronic medica			
		ting up in her wheel chair			record conffiguratton has been			
		was not wearing TED			changed tto allow ffior accuratt&C			
	hose.	was not wouting 1 LD			ttottalstthis change correctts resid			
	11050.				#58's record. The business office			
	0.00000000	10.136.8			manager has been insttructted tto	use		
		10 A.M., Resident #76			tthe error ffiunctton versus tthe d	elette		
	was observed in	her wheel chair in the			ffiunctton when adjusttng tthe cer	nsus		
	hall. She was no	t wearing TED hose.			line. Nurses will be reinserviced or			
					proper documenttatton offi physic	cian		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A PLUI DING 00		COMPLETED			
		155003	A. BUILDING B. WING			08/25/2011		
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1	OVIDENT DR			
MASON HEALTH CARE CENTER				WARSAW, IN46580				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	+	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		4:25 P.M., Resident #76			nottfficatton witthin tthe electtron	nic		
	was observed in	her room in bed. She was		medical record. 4. Residentts witth speciffic needs				
	not wearing TEI	O hose.		4. Residentts witth speciffic (i.e. tted hose) witth be identtff				
					ttheir care plans DON/designee w			
	In an interview of	on 8/24/2011 at 10:05			conductt ffiacilitty rounds/wk x 6v			
	A.M., LPN #6 in	ndicated Resident #76			tto ensure all intterventtons are	-		
	should have her				implementted DON/Licensed			
					designee will auditt 3residentts or	า		
	In an interview	on 8/24/2011 at 10:10			inttake and outtputt monittoring			
		dicated if Resident #76			weekly x3 tto ensure accuratte da	ily		
	· ·				ttottalsThis will be tthen be			
	would have refused her TED hose, it				monittored tthru Q . montthly uni	ttl		
	would have been documented on the				100% compliance is achieved.			
	treatment record				Administtratto/idesignee will moni census line adjusttmentts tto ensu			
					tthe correctt ffiunctton was useth			
	A review of the treatment record, dated 8/2011, included documentation on the				will be done weekly x4 tthen	13		
					quartterly tthru Q A. unttl 100%			
	dates of 8/22 and	d 8/23/2011, indicating			compliance has been achieved.			
	Resident #76 was wearing her TED hose,				DON/Licensed designee will moni	ttor		
	even though the	resident was observed on			nursing documenttatton tto ensu	re		
	those dates not v	wearing TED hose.			accuratte documenttatton offi phy	ysician		
					nottfficattonThis will occur 3x/wk	X		
	2. Resident #58'	s record was reviewed			4wk tthen montthly tthru. Q. unttl			
		10 P.M. Resident #58's			100% compliance is achieved. 5. Septtember24, 2011.			
		led but were not limited to			5. Septtember24, 2011.			
		etes, and breast cancer.						
	depression, diab	etes, and breast cancer.						
	Pavian of intels	e and output records for						
		l on 8/14/2011 Resident						
		te of 360 milliliters (ml)						
	1	0 mls on second shift and						
		shift. An additional 360						
		ed on the form. The form						
	also indicated th	e total consumed was						
	1200 mls. The o	utput indicated on the						

AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE COMPI 08/25/2	LETED	
NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN46580					
			Ş V PR	900 PR	OVIDENT DR	Е	(X5) COMPLETION DATE	
	On 8/24/2011 at Nurse indicated to records were not charting system to resident's intake not able to be vio	1:17 P.M., the Corporate the intake and output correct, the electronic had a flaw and the and output records were tweed in the system. She she was not able to hand						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	(X3) DATE SURVEY COMPLETED 08/25/2011			
NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN46580					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	4. Resident #100 8/25/2011 at 1:0 diagnoses include chronic kidney dementia. A physician's ordindicated to obtathe physician showeight increased 24 hour period. A review of Residucumentation reweight increased May 25, 2011; from 2 2011; and from 2 2011. A review of Residucumentation from 2 2011. A review of Residucumentation from 2 2011; and from 2 2011.	lsc identifying information) l's record was reviewed 5 P.M. Resident #100's ed but were not limited to disease, diabetes, and der, dated 5/14/2011, in daily weights and call build Resident #100's by 1 pound or more in a dent #100's daily weight evealed Resident #100's from 208.6 to 210 on from 209.5 to 213 on May 11 to 213 on June 1, 207.4 to 210.2 on June 6, dent #100's treatment and June 2011 indicated been obtained, and nurse kmarks accompanied the e row headed day.		CROSS-REFERENCED TO THE A		DATE		
	the Director of N record did not in	on 8/25/2011 at 2:15 P.M., Jursing indicated the dicate the physician had cause of the electronic sues.						
	On 8/25/2011 at Team Coordinate	3:15 P.M., the 300/400 or provided						

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 5/2011
	PROVIDER OR SUPPLIEI HEALTH CARE CE		900 PR	ADDRESS, CITY, STATE, ZIP OVIDENT DR AW, IN46580	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	report indicated	via the 24 hour report. The the physician had been veight gains on May 25 e 1 and 6.				
	3.1-50(a)(2) 3.1-50 (a)(3)					